August 29, 2019

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Federal Communications Commission
RE: *In the Matter of Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213
Submitted electronically via: regulations.gov

Dear Secretary Dortch,

OCHIN appreciates the opportunity to comment on the *Matter of Promoting Telehealth for Low Income Consumers* and provide suggestions on how the Connected Care Pilot program should be rolled out to extend telehealth services to underserved patients across the country.

OCHIN is a 501(c)(3) not-for-profit community-based health information technology (HIT) collaborative based in Portland, Oregon. We are the largest Health Resources and Services Administration (HRSA) Health Center Controlled Network (HCCN) in the country, supporting 96 health center in our network. We also deliver best-in-class electronic health record (EHR) technology to 112 organizations on our hosted Epic platform. We operate two national broadband consortia, the Oregon Health Network and California Telehealth Network, utilizing the Federal Communications Commission (FCC) Rural Health Care (RHC) Program. This program is foundational for the services we deliver to health care providers who serve our nation's most vulnerable patients. OCHIN also operates the California Telehealth Resource Center, advancing virtual care and telehealth within the safety net. The patients OCHIN members care for critically rely on the expansion of broadband infrastructure and subsidies provided for continued connectivity, as much of this population resides in rural and geographically remote areas and are often medically underserved.

OCHIN assists providers to access the critical funds of the Universal Service Fund to expand health information exchange, telehealth, virtual care, and health IT. Utilizing the RHC, we bring our members the rapidly evolving technology that transforms their health care delivery process and helps them improve care and to better address chronic disease and gaps in health care delivery. A solely designated pilot program to extend broadband into patient homes in conjunction with an increasingly funded RHC program will encourage participation and increase innovation of telehealth in communities that remain essentially disconnected. The Commission's efforts to improve and promote telehealth and virtual care have made an enormous impact and its continuation will transform rural health care across the nation. OCHIN's experience with the RHC program and telehealth deployment allows us to have a well-educated lens through which to offer recommendations for this Pilot.

OCHIN applauds the FCC for moving forward with this Connected Care Pilot to address medically underserved communities in the U.S. We look forward to supporting the program through further development and maturity.

OCHIN Comments on the FCC Connected Care Pilot

A. Proposing a Connected Care Pilot Program

OCHIN supports the proposal to focus on complex health conditions, including behavioral health, diabetes, and mental health conditions. We further recommend focusing on populations with higher rates of complex conditions and mental/behavioral health conditions, including multiple complex chronic conditions (MCCs) simultaneously. Individuals suffering from tend to have the greatest needs and would benefit the most from this Pilot.

OCHIN recommends the Commission use this opportunity to gather data on complex and underserved communities and leveraging it to improve patient outcomes by identifying the gaps in their care, and how telehealth can extend to fill these gaps. To gain the most from this data, data sharing must be improved, and treatment data paired with claims data to provide a full picture of the cost of care. We support the FCC collaboration with CMS and HRSA to understand gaps and support evaluation of various proposals.

Finally, it is critical the USF, and especially the RHC improve operational efficiency as well as funding levels to coordinate with this Pilot program to continue to extend broadband access. The basis of the Connected Care Pilot is to extend beyond the health care center into the patient home and is predicated on the health care center, should it qualify, having access to the USF funding. We continue to urge the FCC to drive operational efficiency and consistency within the RHC program to ensure success of this new program.

Financial Allocation

Previous efforts by the Commission to fund healthcare-related connectivity have been limited in scope, and we believe that the Pilot must go much further to demonstrate effectiveness. For example, OCHIN urges the Pilot program to assist in covering administrative costs for critical items such as staff administration time, technical assistance, training, tracking, as well as workflow optimization. These are vital to the success of any telehealth deployment, and where a clinic cannot afford the equipment or broadband connectivity, it is unlikely they can acquire reasonably priced training and support elements necessary for success. As an entity well-versed in technological implementation and integration, we can attest that financial inability to ensure a successful integration of this new equipment and the associated processes could disincentivize applications by those clinics and providers who need it the most.

When scoring applications for funding, those providers and organizations able to deploy virtual care with other partners, especially those that support safety net patients and providers, should receive additional points where they are able to outsource integration support through a partnership with an outside organization or a health center controlled network (HCCN). An HCCN is a network of health centers which cooperate to improve access to care, quality of care, and increase cost efficiencies through management, financial, administrative, technological, and clinical support services, but these services must be compensated for.

If the Commission proposes does not fund end-user devices, connected care medical devices, or connected care mobile applications, it will make participation for community health centers and others supporting the safety net much more difficult. These technologies are not only expensive to acquire, but their maintenance, tracking, and storage not only present steep up-front costs, but similarly high maintenance costs. Ideally, the Pilot will provide adequate flexibility to grantees to apply solutions based on the grantee's unique needs, which may include funding allocated for acquisition and upkeep of technological devices. To ensure success of the program, the FCC must ensure that rural and smaller health centers can also fairly and equitably participate in the program.

Legal Hurdles

Insufficient Medicare and Medicaid reimbursement remains an enormous issue. The lack of robust reimbursement rates results in a slowed evolution of technological advancements for these patients, making this area of care ripe for this Pilot to focus on these patient populations. We recommend collaborating with CMS to obtain reimbursement for pre-authorized services for participating health care providers (HCPs).

Interstate medical licensing laws and certification laws must be improved in order to allow transfer of resources from one state to another to address underserved areas and improve capacity. Once the connectivity has been extended to patient homes, the next issue to address is the lack of providers in many communities, whether they are rural or geographically isolated. By extending provider capability across state lines to where their care is needed, patient health improves. By working with agencies, national standards for certification can be created to make transferring these resources simpler.

Where the FCC is considering a focus on substance abuse and behavioral health conditions, it is critical to recognize there are still challenges around data sharing predicated on the current interpretation, interoperability and the application of 42 CFR Part 2. Community health centers and their HCCN partners are best prepared to address these challenges to reach more patients in their community through telehealth applications. Community health centers reach more medically and socially complex patients and this program can further extend their reach in addressing the nation's opioid crisis.

Costs and Funding

OCHIN recommends the Pilot run for 5 years, as 3 years is too short to determine the true return on investment. The time taken to lay the infrastructure to extend this Pilot, train providers and their staff to execute virtual care, and then to see a significant change in the health of the patients is greater than 3 years.

OCHIN believes an 85% discount level is acceptable. OCHIN suggests funding 10-20 pilots that are well thought out to deliver measurable improvements in patient outcomes. It is critical to note that sufficient funding must be provided for each unique grantee approved, lest it results in ineffective and under-resourced programs that consequently underestimate the true impact and benefits of virtual care.

To reiterate statements above, administrative and operating costs should be included in the Pilot funding, as the target providers have small margins and require additional support for training, to adjust workflows, for additional staff to deploy technology directly to patients, and to perform data analysis for reporting purposes.

Finally, it is critical that funding for the pilot program remains separate from the RHC program. OCHIN believes both the Pilot and the RHC program require an increase in funding based on the extensive populations of providers and patients that remain disconnected and unable to utilize the great strides that have been made in telehealth.

Participation

OCHIN supports limiting provider participation to non-profit or public health care providers. Safety-net clinics, health departments, rural clinics, and consortia that support them should be the target of this Pilot. Where the Commission seeks to narrow the applicant pool to entities that require additional support to gain telehealth capabilities, these categories meet that requirement. They are the least likely to be able to afford the broadband connectivity and technology on their own, they often support patients with geographical challenges, and reliably have the most complex patients to care for. However, it is also important to select providers capable of scale.

OCHIN strongly urges the Commission to require a provider to have prior experience with telehealth -OR- long-term patient care, as opposed to experience with both. Requiring the provider to have both removes many clinics from eligibility that could still greatly benefit from this Pilot, and require the Commission's funding to realize a telehealth program to support their communities and patients.

Given the controversies around MSA data distinguishing between rural and urban, OCHIN does not believe these data should be used as criteria in making a distinction for eligibility in this Pilot. Eligibility should be based on need, and not location or statutory classification.

OCHIN approves of grantees having prior experience with integrating remote monitoring -OR- telehealth services. We do not believe TRCs or TCEs should receive this funding but could be consulted if appropriate for a provider's ability to deliver telehealth services.

B. Application Process, Proposal Evaluations, and Selection of Projects

In evaluating proposals and selecting projects, OCHIN suggests focusing on low income, rural, and safety net patients in underserved communities. We also recommend looking at the ability of the grant design to determine how many patients were reached, and what, if any, improvements in patient outcomes were achieved based on documented electronic health record and claims data. Specifically, we recommend using population health data gathered from the health record and, if available, Medicaid and Medicare claims data to identify areas of greatest need.

OCHIN recommends focusing funding towards federally designated health care providers, such as federally qualified health centers (FQHCs), rural health clinics (RHCs), or critical access hospitals (CAHs). In analyzing proposals, projected costs should not be prohibitive, as many of the providers in need of the most support are going to have the smallest budgets to supplement the Pilot funding. It will also be important to note the status of the provider and their experience with virtual care. Providers should not be declined participation for their inability to obtain connected care devices or applications, but instead a system for supplying these technologies should be designed and supported by the Pilot.

The determination should not be whether a project would support primarily rural patients, but the goal instead should be maximizing the population health tools to understand where the greatest need remains, and what services require extension into underserved communities that can be served by this Pilot. It would be beneficial to consult HRSA and HCCNs, as they are aware of these gaps. Additionally, whenever available, goals and metrics of the success of a program should be aligned with existing metrics already being collected by the health center or provider to reduce provider burden.

D. Pilot Program Goals and Metrics

OCHIN highly recommends the Commission consult with other agencies prior to funding applications. Many federal agencies provide broadband funding in varying capacity. OCHIN suggests the federal government improve coordination among agencies to improve efficiencies and increase the number of recipients by making the application process more defined and easier to navigate. OCHIN absolutely recommends coordinating with HRSA, ONC, the USDA, and CMS to ensure broadband is deployed most effectively for telehealth/healthcare as a use case.

Measuring universal services support for connectivity can be done in many ways but would ideally be done through analysis of the treatment data as well as the claims data. For example, many low-income consumers without access to regular primary healthcare may forego care until it becomes dire and then often utilize emergency services, resulting in more costly interactions with worse outcomes. This is especially true when one of more chronic diseases is present such as diabetes or hypertension. Often this is the result of residing in an underserved area which requires extensive travel to visit either a primary care provider or a specialist. When these individuals have regular contact with a provider and can utilize telehealth services, they receive more timely care, and can better manage their health.

As this Pilot progresses, analysis of the data will show likely fewer emergency department visits, and higher levels of contact between patients and providers, which leads to better outcomes for patients. Costs to the health care system and to patients, including transportation and time off work, may be greatly reduced. As a result, OCHIN believes the highest impact will be where the Pilot focuses on connecting patients to primary care and behavioral health providers.

Providers who support those within the safety net are chronically underfunded. At times, these providers must choose between upgrading their technology (e.g., their electronic health record system) or implementing telehealth and having enough care staff on hand on a given day. However, it’s never simply the acquisition of the upgrade that depletes these tight budgets, but the training, maintenance and further upgrades, educating patients on the technology changes, and shoring their participation. These administrative and operational costs must be accounted for, and assisted with, to see a full return on this Pilot. Because of the many areas where virtual care can be applied to improve patient care, this program is critical to controlling health care spending costs, improving care delivery, and reducing provider burden. By allowing funding to be used for these costs, the FCC can make sure safety net providers are not left behind by participating in this movement towards virtual care.

E. Data Gathering and Reporting

Clinical Trials

OCHIN strongly suggests using evaluation rather than clinical trials when looking at outcomes of this program. Clinical trials are costly and where this program is aiming to support the underserved and safety net populations, their providers do not have the funding available internally to undertake such an intensive method of reporting in exchange for this funding. If additional funding is available to support clinical trials, this may be worth consideration, but it will inevitably reduce the number of applicants and discourage participation for smaller clinics that do not have experience with clinical trials. Where the FCC is considering non-profit and public health entities as the target of this Pilot, clinical trials will likely be too burdensome. Additionally, should the FCC remain firm on the 3-year time frame, OCHIN believes this will not provide enough time for a successful clinical trial.

The data collected from each Pilot project should look holistically at patients' health outcomes, experience, and improved overall wellness. The Commission should examine cost savings to the health care provider as well as the patient population (e.g., transportation, child care, lost wages). As stated previously, OCHIN strongly supports aligning metrics, when possible, to current workflows or metrics being captured by the provider to reduce further provider burden. It is critical to determine the full breadth of impact and cost savings in implementation of this Pilot as opposed to the impact on a single health factor.

Please contact Jennifer Stoll at stollj@ochin.org should you have any questions.

Sincerely,

Jennifer Stoll
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